

GENERAL DESCRIPTION AND FLOW COMBINED ENROLLMENT FORM

The CSHCS / First Steps / MCH / Hoosier Healthwise **COMBINED ENROLLMENT FORM** is used to submit all participant related information to the Central Reimbursement Office (CRO), CSHCS, MCH and Hoosier Healthwise computer systems.

The multi-part form is divided into two major sections, PART I Enrollment application and PART II, Social History, which contains separate data entry fields. [With a few exceptions, all fields appropriate to a specific category/status of a participant are critical fields and require an entry.]

The combined form was jointly developed by CSHCS, MCH, First Steps and Hoosier Healthwise to be used by all four programs. This was done in an effort to help coordinate program activities and to avoid duplication of data collection in those areas where one or more of these programs operate. This information may be forwarded on to the WIC program if the family is in need of those services.

Consequently, reasonable care must be taken in the storage and handling of these forms. Blank forms should be kept in a secured location.

GENERAL INPUT CONSIDERATIONS

The following general rules of input should be observed when completing the **Combined Enrollment Form**:

Only **black or blue inked pens** should be used. All entries should be clearly printed within the appropriate sections.

DETAILED FIELD DESCRIPTIONS

The following is a detailed field by field description of the **Combined Enrollment Form**. Information collected on the enrollment form must be UPDATED at least ANNUALLY. Due to the different needs and requirements of each program, some of the data sections are to be completed only by a specific program and are not necessarily completed by all four programs. For some other sections, the coding used by each program is slightly different. Where differences do exist, appropriate notes are included to highlight the special coding for each program. Each program is responsible for correcting the form received from the other program where coding differences do exist.

DATA FIELD INSTRUCTIONS

All areas in ***bold italics*** need to have data entered on the enrollment form.

PART I ENROLLMENT APPLICATION

County of Residence of Participant:

Used by all programs. Enter the appropriate county name.

Application Date:

The signature date of the guardian/parent/participant should be this date.

For MCH: The date the enrollment form was completed. [For CSHCS the application date for Children's Special Health Care Services will be the date of this signature as long as financial and social information necessary to complete this application is provided within thirty days. If such information is not provided, the application will be denied for failure to cooperate in the application process. A new application will be \(?\)](#)

Enrollment Date:

(This field is only used by the State CSHCS Eligibility Unit.)

FIRST STEPS (These fields are only to be used by FIRST STEPS staff.)

SPOE Number:

Enter SPOE identification number.

I.D. Number:

Enter the participant's identification number assigned by the CRO.

New Referral:

This field is to be checked when adding a new participant who has never been enrolled in the First Steps program.

Re-referral:	Check this field if the family had begun the referral process at an earlier date.
Annual Update:	Check this field if the family has completed the yearly IFSP review, or changes in circumstance, i.e., address, income.
Other:	Check if the family has come to the SPOE for completion of the application for other reasons than First Steps enrollment. Indicate reason.

MCH (Only MCH staff enters information in these fields.)

Agency:	Issued by the MCH data system. Identifies the MCH project name or number into which the applicant is being enrolled.
Clinic:	Issued by the MCH data system. Identifies the MCH clinic within the MCH project into which the applicant is being enrolled.
I.D. Number:	Issued by the MCH data system.
New Enrollment:	This field is to be checked for a new participant. Such a participant will never have been enrolled in your MCH project in any clinic or service.
Annual Update:	This field is to be checked when completing an annual update of the enrollment information for a participant. Projects are expected to complete an enrollment form each year for all participants. This verifies that the participant is eligible for the program and maintains accurate demographic information.
Services:	<p>This field indicates the type of MCH services into which the participant is being enrolled or reinstated.</p> <p>Codes are:</p> <ul style="list-style-type: none"> Prenatal Care Prenatal Care Coordination Prenatal Substance Use Prevention Program Child Health Family Planning Women's Health Family Care Coordination Postpartum Care Adolescent Services
Third Party Payment Source:	<p>This field indicates that source of third party payment made on behalf of the MCH client fee for the MCH services provided. Third party payment reimbursement is paid directly to the clinic for services rendered to the participant. Only one-third party source can be recorded. Prioritize as follows: private insurance, Medicaid (Title XIX), Title X, and Title XX.</p> <p>Codes are:</p> <ul style="list-style-type: none"> Medicaid (Title XIX) CHIP (Title XXI) Private Insurance Title X (Family Planning) Self Other None

CSHCS

Agency:	(Only the State CSHCS Eligibility Unit uses this field.)
----------------	--

Clinic:	(Only the State CSHCS Eligibility Unit uses this field.)
I.D. Number:	Completed by the State data system. This identification number is specifically used for the CSHCS data system and remains with the child from enrollment on whether the child is eligible or denied for the program or if s/he should reapply. This number is assigned by the CSHCS data system.
New Enrollment:	This field should be checked when adding a new participant who has never been on the CSHCS program.
Re-application:	This field should be checked when reinstating a participant who is reapplying. The <i>original I.D.</i> number will be retained.
Re-evaluation:	This field is completed by the local/state CSHCS Care Coordinators during the annual re-evaluation process.
Child is Medically:	Eligible/Ineligible This field is completed by the state CSHCS Eligibility Unit on the initial application and is reviewed during the annual re-evaluation process by the CSHCS Care Coordinator.
Child is Financially:	Eligible/Ineligible This field may be completed by the CSHCS Eligibility Unit, Local/State CSHCS Care Coordinators, First Steps SPOE and First Steps Service Coordinators (where appropriate) on the initial application and by Local/State CSHCS Care Coordinators during the annual re-evaluation process.
Date Eligibility Determined:	This field is completed by the CSHCS Eligibility Unit only on the initial application.

HOOSIER HEALTHWISE

New Enrollment:	This field should be checked when adding a new participant who has never been on the HH program.
Re-application:	This field should be checked when reinstating a participant who is reapplying. The <i>original I.D.</i> number will be retained.
Pending:	Indicates application has been sent for processing.
Current:	Actively enrolled in a HH program.
N/A:	Family is extremely over income to be eligible for HH.

MEDICAID DISABILITY

New Enrollment:	This field should be checked when adding a new participant who has never been on the MAD program.
Re-application:	This field should be checked when reinstating a participant who is reapplying. The <i>original I.D.</i> number will be retained.
Pending:	Indicates application has been sent for processing.

Current: Actively enrolled in a MAD program.

N/A: Family is extremely over income to be eligible for MAD.

SECTION A. Participant Information

Last Name/First Name/MI: Write the last name, first name and middle initial (optional) in the space below each identified field. This should be the participant's legal name and not a nickname. Only enter *one applicant's name* in this section.

DOB (Date of Birth): Use numerical entries 00/00/0000

Known As (AKA): Complete if applicant is known by another name, or nickname.

Street Address: This is the participant's street address, inclusive of apartment number, rural route, field number, etc. Abbreviations are acceptable.

NOTE: *For a homeless person with no address, either the word NONE or the address of the site of application may be entered. If possible, obtain an address where the homeless person may receive mail for notification of approval or denial, etc.*

City/State: The two-digit state abbreviation can be used for the state of residence.

Zip Code: The participant's postal zip code appropriate for his/her address. Can include the zip plus four.

Telephone: This telephone number with area code (A/C) identifies the location where the participant or the participant's parent or legal guardian may be reached.

Mother's Maiden Name: This is helpful for participant identification purposes.

SECTION B. Parent/Legal Guardian/Foster Caseworker

This information is optional for MCH programs.

(SURROGATE PARENT-information and signature can only be used for Early Intervention (FS) Services)

Provide absent parent name and address, if known, for Hoosier Healthwise application. This information is not mandatory.

Complete Address Sections one and two when there are multiple caregivers responsible for the participant.

Last Name/First Name/MI: The parent/legal guardian/Foster Care caseworker's name(s) should be entered here. When enrolling in the First Steps Program, a child may have a court appointed surrogate parent in lieu of a parent or legal guardian for the purpose of seeking early intervention services. In such circumstances, the surrogate parent's name should be listed along with the parent /legal guardian/Foster Care Caseworker's name(s).

Address if Different from Participant's Address: Include the address of *the parent/legal guardian/Foster Care Caseworker or surrogate parent* if the address is different from the participants.

City/Town/State: Provide the name of the city or town where the parent/legal guardian/Foster Care Caseworker resides and the state. Abbreviations are acceptable.

Zip Code:	The person's postal zip code appropriate for his/her address.
Home/Office/Other Telephone:	These telephone numbers identify the location where the person's parent/legal guardian/Foster Care Caseworker and/or surrogate parent may be reached.
Intake Coordinator/ Interviewer:	<i>The program staff person who completed the application should sign here regardless of agency affiliation.</i> Please indicate business address and telephone number where you may be contacted for further questions regarding information on the application.
On-going Service/ Care Coordinator:	The person to whom the eligible case for First Steps or CSHCS has been assigned <u>(if applicable)</u> . If this information is not known at the time of application, forward the form to the agencies so that it can be completed at a later date.

SECTION C. List all Persons (Including Participant) Who Live in Your Household

Household means all the persons who occupy a housing unit (house or apartment), whether they are or are not related to one another, and who are living together. For income calculations refer to specific agency definitions of who to include.

Name: Enter the names of all individuals living within the "household" (as defined above). List the applicant's name first.

Relationship: Relationship of the participant identified in Section A. Record either the title acronym for the relationship or enter the codes listed below:

Codes are:

0 = Head of Household (use for MCH family care coordination)

1 = Child

6 = Other

11 = Spouse

2 = Grandparent

7 = Foster Care

12 = Foster Care Sibling

3 = Sibling

8 = Self

13 = Significant Other

4 = Aunt or Uncle

9 = Guardian

14 = Parent of Spouse/Significant Other

5 = Parent

10 = Step-parent

15 = Stepchild

For Hoosier Healthwise purposes, please abbreviate the relationship of the household member to the applicant. (Example: M=Mom, D=Dad, Br.=Brother)

DOB: Enter the date of birth of all listed.

Marital Status: List as appropriate

Codes are: M = Married S = Single D = Divorced E = Separated U = Unknown

Gender: Enter male/female (M / F) or A (ambiguous)

Race/Ethnicity: Use both of the codes listed below to identify race and ethnicity as per the participant's stated preference or, if none is stated, based on the visual observation of the clinic staff. Follow the Race code with a slash (/) to separate it from the Ethnicity code.

Race Codes:

W = White

B = Black

A = American Indian or Alaskan Native

API = Asian or Pacific Islander

M = Multi-racial

U = Unknown or not specified

Ethnicity Codes:

N = Non-Hispanic

M = Mexican

C = Cuban

CSA = Central and South American

PR = Puerto Rican

OH = Other Hispanic

HU = Hispanic unknown

Please use abbreviations for race and ethnicity. (Example: B/N = Black, Non-Hispanic.)

NOTE: Race code U should only be used as a last resort so as not to distort racial/ethnic statistics. Bi-racial children should be classified using the race specified by the parent or guardian.

Migrant/Homeless:

Indicates the status of the participant as a migrant farm worker or a homeless person. If the person is both migrant and homeless, code as a migrant. Only Indiana residents may make application to First Steps/CSHCS/Hoosier Healthwise.

Codes are:

1 = Non-migrant and not homeless.

4 = Homeless

5 = Shelter

6 = Institution

7 = Temporary Residence

8 = A homeless individual whose primary nighttime residence is a public or private place not designed as a regular sleeping place (i.e., church, etc).

9 = Migrant – A migrant farm worker

Education level:

Indicate the highest-grade level completed by each household member.

Preschool

Some college

Head Start

College graduate

K - 12

Technical school

High School graduate

Graduate school

GED

Use 99 if educational level is unknown.

Preg (Y/N):

Enter Yes (Y) or No (N) when appropriate for each female household member. If applying for **Hoosier Healthwise** for the listed person who is pregnant, documentation from a licensed health care professional verifying date the pregnancy was first confirmed, delivery date and number of fetus(es) is needed.

US Citizen (Y/N):

This is not a required field for CSHCS/MCH/FS. Enter Yes (Y) or No (N) to indicate whether the household member is a US citizen, if they are applying for Hoosier Healthwise. If not a US citizen, provide documentation on how they are in the country. Immigration card should be verified by providing a copy of their Immigration and Naturalization Services card. Record identifying registration number regarding immigration status on the application. *If participant or family is not a legal resident this information WILL NOT be reported to INS.*

PMP(Y/N):

Enter Yes (Y) or No (N) whether each person has a PMP (primary medical provider).

SSN # – (Social Security Number)

A Social Security Number should be given for each applicant. An applicant who does not have a number must apply for one. Exception: This requirement does not apply to applicants who qualify for health coverage under Benefit Package C. The number(s) you provide will be used to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development and other state and federal agencies. This is required by Section 1137 of the Social Security Act. We ask for the Social Security Numbers of family members, however, it is not required that you provide them.

Recipient ID:

The **Hoosier Healthwise** Indiana Client Eligibility System (ICES) case number assigned to the participant from the Department of Family & Children (DFC).

INS (Y/N):

Enter Yes (Y) or No (N) for each household member if s/he has health insurance coverage other than **Hoosier Healthwise**. Complete the insurance document specifically for each policy that the participant may have.

Check if household members are also applying for Hoosier Healthwise:

This application may be used to enroll several family members within the **Hoosier Healthwise** program.

Total Household:

*CSHCS definition of household. (See definition under Section D.)

Adjusted Household:

**Hoosier Healthwise, MCH definition of household. (See definition under Section D.)

SECTION D. Income Verification

This section is used to determine income eligibility for all programs utilizing the appropriate definition for household.

***CSHCS “Household” definition means a group of two (2) or more persons living together as one (1) economic unit. When the child is a foster child or emancipated, they are a family of one (1). Two (2) separate households or economic units may reside under one (1) roof; however, each household must be economically independent of one another and must have its own source of income that is adequate to support itself without support from the other family.**

****To determine income use the Assistance Group definition for MCH/Hoosier Healthwise. The Assistance Group is an individual or group of individuals whose income, resources, needs, and/or expenses are considered together in the eligibility determination for an assistance category. (The pregnant woman is counted as a unit of two or herself plus the number of fetus). MCH refers to this as the Adjusted Economic Unit.**

Household Income:

Identify the **names** of all individuals (within the household) receiving an income; enter the **individuals’ income sources** in each of the columns one through three, as appropriate, stating the **amount and frequency** of earnings for the specific categories listed in the left column of the chart.

Monthly Total:

MCH does not require proof of income.

Calculate the monthly total for each source of income line and record the total on the appropriate line(s) in the far right column, only for CSHCS. CSHCS only requires one month of income proof.

Hoosier Healthwise will calculate, at the OFC, the family’s income from provided documentation. Hoosier Healthwise applications request information on an additional three months by asking the question, “Is this month’s income the same as the previous three months?” If the previous three months income does vary and the family wishes to receive benefits for those months – income information must be included, which may be accomplished by duplicating the family’s income documentation. If not available, you may send an employer verification form to the employer to be returned to the person taking the application. If the prior three months income is not available, and the applicant does not wish to have benefits during that time period, then one month’s income information may be submitted with the application. If you are unable to make copies of the pay stubs, a visual verification of pay stubs may be utilized when a written example of the complete pay stub is provided and a signature of the intake person who recorded this information is included.

NOTE: *If more than three persons are reporting income, add an additional form for this section and total all persons’ incomes defined within the appropriate household definition.*

INCOME GUIDELINES: Listed below. (Used to determine the financial eligibility for the **CSCHS program only**).

Proof Of Income for applicant. To verify a household income, one of the following may be reviewed:

If the family is making an application to Hoosier Healthwise the following must be provided:

Documentation of the household (see definition) income, the month they are applying, plus the three prior months income. This information is to be sent to the local office of Family & Children with the application.

- a. Check stubs from the three most recent consecutive pay periods.
- b. Most recently filed 1040 Federal Income Tax form.
- c. Written statement from the employer regarding salary/wages.

ADDITIONAL GUIDELINES:

<u>Farm Income</u>	May be determined from the most recently filed Federal Income Tax form (1040, line 22).
<u>Non-farm Self-Employment</u>	May be determined from the most recently filed Federal Income Tax form (1040, line 22).
<u>Wages, Commissions, Fees</u>	May be determined from the most recently filed Federal Income Tax form (1040).

Income INCLUDES The Following:

- Public Assistance or TANF payments
- Wages, Salary, Commissions, Tips, Fees
- Net income from farm
- Net income from self-employment
- Social Securities
- Alimony or Child Support
- Unemployment Compensation
- Private pensions or annuities
- Strike benefits
- **Earnings of a child:** The financial compensation for services or income from self-employment received by a child residing in the home who is under 18 years of age, and who is attending at least half-time, a grade school, high school, vocational school, college or university allowing for customary vacations and breaks is taken into consideration.
- **Other cash income:** (Includes, but not limited to: cash amounts received or withdrawn from savings, investments, trust accounts, lottery or other prize winnings and settlements or awards resulting from lawsuits; monetary gifts; contributions and funds raised by popular subscription.)
- Net rental income
- Sick benefits
- Income from estates or trusts
- Dividends or interest on savings, stocks or bonds
- Government pensions, civilian or military or veterans payments
- Regular contributions from persons not living in the household
- Net royalties

DO NOT Consider The Following As Income:

- Payments received from the Home Energy Assistance Act.
- Assistance to children from the National School Lunch Act, the Child Nutrition Act, and Food Stamp Act.
- Reimbursement from the Uniform Relocation Assistance and Real Property Acquisition Policies Act.
- Payments to volunteers under VISTA or RSVP (foster grandparents); also, SCORE and ACT of the Small Business Act.
- Payments from the Job Training Partnership.
- Educational grants and student loans.
- College or university assistantships.
- Subsidized housing.
- Food allowance or subsidized housing for military personnel.
- **Do not count SSI (for CSHCS only).**
- Temporarily living within another household for less than six months; ONLY the income of child or family applying for the CSHCS program shall be used in CSHCS income calculations.
- If the participant states they receive no income, document on a separate paper how they receive economic support for food, shelter, clothing, health care and other needs; include dollar equivalent where applicable.
- Foster children are viewed as a family of one, as wards of the State. Any foster care payment to the family is not to be included in the income calculation. The foster child is viewed as a temporary boarder status.

How To Calculate The Monthly Total – (for CSHCS only)

To average you must utilize the 4.3 weeks per month to establish a correct monthly salary.
Always use the income amount before taxes are deducted (gross income).

NOTE: *The monthly total is to be averaged over a twelve-month period when there are sporadic periods of employment, utilizing the 4.3 weeks per month calculations.*

- Weekly salary (if it is always the same amount) multiply check stub x 4.3 weeks = monthly total.
- Bi-weekly salary, averaged check stub amount divided by two then multiply this amount x 4.3 = monthly total.
- Twice a month salary, multiple check stub x two (if they are both the same amount) = monthly total. If the check stub amounts are different then add together the two amounts to get a monthly total.

- If there is a variance in weekly pay, add three different pay stubs, divide by three (to get average weekly) then multiply by 4.3 = monthly total (may use four or more and average calculation by the number of pay stubs utilized).
- If the income varies tremendously use the gross income amount from the most recent 1040 Federal Income Tax form.
- A written statement from the employer verifying salary is needed if there are no pay stubs.
- For the self-employed person, request last year's tax form 1040, Line 12, Farm Income, Line 18.
- For the unemployed person, verify participation in Hoosier Healthwise or food stamps.
- For two families living in one house, consider each family as an economic unit only if they are economically independent of one another as described under **Proof of Income Section** regarding the definition of **Family** for the CSHCS program.
- If the applicant is temporarily supported by another person, consider only income the unemployed person may have. As described by *CSHCS Title 410 Indiana Rules*, *Temporarily* means "for purposes of determining financial eligibility, a participant or family is temporarily living within another household or family if the participant lives within the family or household for six (6) months or less."
- Add all of the monthly totals together to come up with the **monthly household** total, rounded to nearest dollar amount: >.50 round up <.49 round down.
- Record the total amount of the monthly household total(s) on the total household income line.

Proof of Income was verified (check stub, tax form, or written

statement) by:

Circle what source was used to verify income from the list in the parentheses above. The SPOE Intake Coordinator, First Steps Service Coordinator, OFC worker, or _____ CSHCS Designee/Care Coordinator (if applicable) should **sign** on the line verifying proof of income was witnessed at intake.

If no income, how are you supported?

Ask the parent/legal guardian to identify how the household is being supported and make a notation on the line.

Is this month's income the same as the previous three months? Yes/No

This information is needed to make application for Hoosier Healthwise to receive the previous three months of coverage, if eligible. No further income documentation is necessary if the income amount is the same on a monthly basis.

Income verification sent to employer (date):

Provide the date that the Hoosier Healthwise employee income verification form was sent, if the family does not have income documentation.

Are you currently paying childcare to maintain employment? Yes/No

This information is necessary for Hoosier Healthwise applicants. Hoosier Healthwise allows childcare payments to be subtracted from the family's gross monthly income.

Is Participant Blind/ Disabled and/or Receiving SSI?

Check the appropriate Yes or No box to indicate whether or not the participant is blind/disabled and/or receiving Supplemental Security Income (SSI).

Do you pay for care of an incapacitated adult?

Check the appropriate Yes or No box. Hoosier Healthwise utilizes this information for income calculations.

Does anyone living in the household pay support payments?

Check the appropriate Yes or No box. This information is utilized by Hoosier Healthwise for income calculations.

Poverty Level Based upon Income:

Check the field which identifies the percentage range of poverty within which the household is living. The percentage level may be found on the Income Eligibility guidelines for WIC/MCH/CSHCS programs. These guidelines change yearly.

NOTE: Use the most recent federal Health and Human Services Poverty Income Guidelines. Income eligibility for the CSHCS program is up to 250% of poverty. Hoosier Healthwise is up to 200% of poverty, WIC is up to 185% of poverty and MCH is a sliding fee.

MCH Income Eligibility at: MCH only: This field designates the percentage the MCH participant is paying for services provided. It correlates to the MCH Sliding Fee Scale.

SECTION E. Medical Insurance Summary

This information is not required for MCH.

Participant Identifying Information (#1): Enter the name, address, city, state and zip code, along with DOB and SPOE/CSHCS identification number, if participant is currently enrolled in either program.

Hoosier Healthwise Information (#2): Enter the applicant's Hoosier Healthwise number. Provide the appropriate coverage dates. A separate Section E of the form needs to be completed for every applicant. Fill out and provide the appropriate date for one of the following: Current Coverage, Pending, Not Financially Eligible, Not Medically Eligible.

NOTE: *Children applying to CSHCS must apply to Hoosier Healthwise whether or not financially eligible.*

Did participant lose health insurance coverage in the past three months? Check the appropriate Yes or No box and, if Yes, provided the date and reason insurance coverage ended. This information is necessary for Hoosier Healthwise application.

Policyholder Information (#3): Enter the appropriate information regarding name, address, city, state, zip code and telephone number, along with relationship to participant of the person who has acquired the insurance policy.

Insurance Company Information (#4): Enter the name of the insurance company, address, city, state and zip code. Check the appropriate insurance coverage type applicable to this policy.

Policy Number (#5): From the participant's insurance card obtain the following information: ID # (usually the policyholder's Social Security number), group number and effective and/or termination date of the insurance policy.

Employer Information (#6): Enter the name of employer, address, city, state, zip code, telephone number and start date of employment.

Coverage Information (#7): Complete the appropriate sections A – I, where applicable for the insurance policy coverage. If the family does not have their insurance policy information, call or request that they contact their member services number to inquire about their coverage information.

Confirmation of information is documented with your signature and the date the form was completed.

CHECK ONE: Check the program where you work. First Steps Intake/Service Coordinator, CSHCS Care Coordinator, OFC Caseworker, or MCH staff.

PART II SOCIAL HISTORY INTERVIEW

SECTION A. Participant Information:

Provide the participant's name, current school and grade level and/or current child care provider. This information is necessary for IFSP transition and/or IEP (Individual Education Plan) for the special needs children. Indicate the school district where the participant resides.

SECTION B. Reason for Referral to CSHCS:

A short statement of the medical concerns for application to the CSHCS program is necessary. Referral information for the FS program may already be on the First Steps referral form and should not need to be replicated, unless additional information is being noted.

SECTION C. Screening/Assessment/Testing:

This field is applicable for participants who indicate that assessments and/or screenings have been completed. It is important to record the results to provide follow-up by service/care coordinators when enrolled in various programs. If there are concerns about lead screening or high lead level issues contact the Indiana Family Helpline at 1-800-433-0746 to obtain information from the Indiana Childhood Lead Poisoning Prevention Program.

SECTION D. Health Care Received:

The physician's clinic, dentist and any specialist physician names and addresses are necessary to provide linkages and access. The PMP # (Primary Medical Provider number) is obtained from the practitioner's office staff, if the practitioner is a Hoosier Healthwise provider. A local list of PMP numbers may be obtained by contacting the county(s) First Steps office. Indicate the reason and the date the participant was last seen by the medical provider.

SECTION E. What is Happening Now for the Participant and Family?:

Indicate whether the participant/family is currently enrolled in the following social services or an application is pending (include date of application). If there are immediate questions and/or needs of the family, please refer the family to the Indiana Helpline of ISDH, telephone number **800-433-0746**.

If there is a Yes answer in subsection two, there are several programs the family can access through the Helpline or their assigned service/care coordinator when enrolled in the various programs. Complete subsections three through six to indicate the equipment, supplies, medications and/or special diet that are utilized by the participant.

SECTION F. Developmental Milestones:

These fields are necessary for application to the First Steps/CSHCS programs. If the developmental milestones have been achieved give the approximate age when the child mastered the skill. If the parent cannot remember specific dates but knows the child has mastered the skill please indicate with a check. Provide comments for areas that need further clarification.

SECTION G. Pregnancy, Birth & General Health History:

These fields are necessary for application to the First Steps program. All the other programs may or may not need to complete this section. If the pregnancy and birth history have an impact on the services being provided for the participant or family, it is a required field. Complete questions one through fourteen where appropriate. Provide any additional information shared during the interview at the end of this section.

NOTE: *The following instructions are for individual program forms that need to be completed when applying to these programs.*

CONSENT FOR COLLECTION OF INFORMATION:

Review the information on both sides of the form with the family. This consent informs them they are agreeing to allow information to be collected on an electronic database (CRO, or others). All information will be kept confidential and will only be used for program enrollment and statistical data collection. Used by all programs - MCH, FS, CSHCS, and HH.

IMPORTANT INFORMATION ABOUT HOOSIER HEALTHWISE:

Review this information with the family regarding the participant's rights when participating in the Hoosier Healthwise program. There are new qualifications within the Hoosier Healthwise program that need to be discussed with the family. The parent or participant applying to Hoosier Healthwise MUST sign the back of this form. A copy should be given to the family and, if applicable, placed in the FS/CSHCS file(s). The original should be mailed to the local OFC Hoosier Healthwise office, along with the completed Part I and Part II of the Combined Enrollment form.

APPLICATION FOR ENROLLMENT WITH THE CHILDRENS SPECIAL HEALTH CARE SERVICES (CSHCS) OR MATERNAL CHILD HEALTH (MCH):

Use this form to explain the rights and responsibilities of the parent/participant within the MCH/CSHCS programs. Have the participant/parent/legal guardian sign and date after this information has been reviewed. As the intake/ongoing coordinator/interviewer, please sign and date the form as well. A copy should be given to the family and included in the First Steps file (if applicable). Mail the original to CSHCS and/or MCH, along with the completed Part I Combined Enrollment Application and Part II Social History Interview.

CONSENT TO RELEASE AND SHARE MEDICAL INFORMATION

Review the rights and responsibilities information on the reverse side of the form with the family. The family should complete and sign this form to request medical documentation from physician(s) who have provided medical care to the participant. A cover letter explaining the need for specific medical documentation is recommended. The Physician

Health Summary form should be included with the cover letter, which allows the doctor to summarize the participant's medical history. (Utilizing the Physician Health Summary prevents excessive duplication of medical records.) Used for MCH, FS, CSHCS, and HH.

NOTE: If the participant has more than one provider, complete a separate Physician Health Summary form for every provider or hospital from which medical documentation is being requested.

PHYSICIAN'S HEALTH SUMMARY FORM:

This form, along with the consent to release and share medical information, should be sent to the participant's physician's office with a cover letter explaining the need for enrollment medical information. The physician or a member of his medical staff should complete the form. The physician's signature must be included with the participant's medical diagnosis. Used for MCH, FS, CSHCS and HH.

Make sure you complete the “**Please return to**” section, with the name and address of the agency that will be collecting the Physician Health Summary for enrollment processing. For example: the local First Steps SPOE office; MCH program office; OFC office; or the CSHCS office located at 2 North Meridian Street, #7B, Indianapolis, IN 46204.

DUPLICATE THE ENTIRE COMBINED ENROLLMENT PACKET FOR ALL APPROPRIATE AGENCY REFERRALS, STAPLE AND MAIL TO THE CORRECT AGENCY(IES) FOR PROCESSING.



CHILDREN'S SPECIAL HEALTH CARE SERVICES INDIANA STATE DEPARTMENT OF HEALTH

ENROLLMENT CHECKLIST

Participant's Name _____

CHSCS Case Number _____

- ☐ Combined Enrollment Form **Parts I and II** with Signatures and Date.
(Verify Birth Certificate, Proof of Residence, SS# if not newborn)
 - ☐ Sent Combined Enrollment form to **Hoosier Healthwise** (if child is not enrolled in Hoosier Healthwise). **(THIS IS MANDATORY.)** Date Enrollment form mailed: _____
 - ☐ **Medical Insurance Information**; Page 3 of Part I
(Verify insurance card(s) information, provide code if possible)
 - ☐ Signed **Rights & Responsibility forms** for every program for which the participant is applying.
 - ☐ Signed the **Data Consent for the Collection of Information**.
 - ☐ Reciprocal **Consent to Release and Share Medical Information** form (copy).
Consent to Release Forms to be sent to providers requesting medical documentation, with a cover letter from your agency to receive information back, unless medical documentation is included with the application. Include the Physicians Health Summary when appropriate.
Date Reciprocal Consent mailed: _____
 - ☐ **Medical Documentation** - (Hold application until medical documentation is received and send all medical documents in with the application.)
- NOTE: Use of the **Physicians Health Summary** may be sufficient medical documentation.
- ☐ Informed the family that the application was sent to:
_____ WIC _____ MCH _____ CSHCS _____ Hoosier Healthwise _____ First Steps
 - ☐ Check here if this is an application for **diagnostics**.
 - ☐ Recommendation for case denial (if application is signed by the family, it must be submitted to CSHCS along with the CSHCS denial form)

Person taking Combined Enrollment Form Application(s):

Name: _____

Telephone #: _____

Agency Name: _____

Agency Address: _____

Please mail all documents to:

**Children's Special Health Care Services
Indiana State Department of Health
2 North Meridian Street, Section 7-B
Indianapolis, IN 46204
ATTN: Eligibility Division**

NOTE: If referring to First Steps, please make a copy and forward to the local SPOE.
If referring to Hoosier Healthwise, please make a copy and forward to the local OFC.



HOOSIER HEALTHWISE ENROLLMENT CHECKLIST

Participant's Name _____ Date of Birth _____

- ☐ Completed COMBINED ENROLLMENT FORM (Part I & II)
- ☐ Completed Hoosier Healthwise Supplemental forms (as appropriate)
 - ☐ Application for Hoosier Healthwise for Children and Pregnant Women Supplement
- ☐ Signed RIGHTS AND RESPONSIBILITIES UNDER THE MEDICAL ASSISTANCE PROGRAM consent form. (Two signatures from the parent and one signature from the interviewer are required.)
- ☐ Income verification (one month's income verification must be enclosed...if the previous 3 months income varies, please provide verification for those months' income as well).
- ☐ Supporting medical documentation verifying pregnancy to include number of fetuses, if applicable.
- ☐ Selection of a primary care physician has been made through the Benefit Advocate.
Name of physician _____
(If selection of a primary care physician has not been made, one must be selected within 10 days of submission of the enrollment packet.)

Person taking enrollment application:

Name: _____

Telephone #: _____ Fax #: _____

Application Date: _____ Date mailed/delivered: _____

Completed enrollment packet must be received at the local Office of Family and Children in the county in which the child resides within 35 days of the application date. (Please see the First Steps/Hoosier Healthwise contact list for specific names and addresses.)

If applying for **MEDICAID FOR THE DISABLED (M.A.D.)**

In addition to the requirements above,
Please include the following:

- ☐ Memo to the OFC staff to review the file for M.A.D.
- ☐ Signed RECIPROCAL MEDICAL RELEASE for any medical providers from which information may need to be sought.
- ☐ Signed PHYSICIAN'S HEALTH SUMMARY to include information on the diagnosis, medical condition and any medications taken.
- ☐ Supporting medical information that may be helpful in determining the child's medical needs.



STATE OF INDIANA COMBINED ENROLLMENT FORM



State Form 49006 (R/1-00)

INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES (MCH)
CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

FAMILY AND SOCIAL SERVICE ADMINISTRATION/
DIVISION OF FAMILY AND CHILDREN/BUREAU OF CHILD DEVELOPMENT
FIRST STEPS EARLY INTERVENTION SYSTEM
HOOSIER HEALTHWISE

PART I ENROLLMENT APPLICATION

COUNTY OF RESIDENCE OF PARTICIPANT				APPLICATION DATE		ENROLLMENT DATE	
FIRST STEPS	SPOE		I.D. Number	<input type="checkbox"/> NEW REFERRAL	<input type="checkbox"/> ANNUAL UPDATE		
				<input type="checkbox"/> RE-REFERRAL	<input type="checkbox"/> OTHER:		
MCH	Agency	Clinic	I.D. Number	<input type="checkbox"/> NEW ENROLLMENT	THIRD PARTY PAYMENT SOURCE: _____		
				<input type="checkbox"/> ANNUAL UPDATE	SERVICES: _____		
CSHCS	Agency	Clinic	I.D. Number	<input type="checkbox"/> NEW ENROLLMENT	CHILD IS MEDICALLY:	CHILD IS FINANCIALLY:	DATE ELIGIBILITY
				<input type="checkbox"/> REAPPLICATION	<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> ELIGIBLE	DETERMINED:
					<input type="checkbox"/> INELIGIBLE	<input type="checkbox"/> INELIGIBLE	_____
HOOSIER HEALTHWISE			<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REAPPLICATION	<input type="checkbox"/> PENDING	<input type="checkbox"/> CURRENT	<input type="checkbox"/> N/A
MEDICAID DISABILITY (MAD)			<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REAPPLICATION	<input type="checkbox"/> PENDING	<input type="checkbox"/> CURRENT	<input type="checkbox"/> N/A

SECTION A. Participant Information

LAST NAME		FIRST NAME		MI	DOB	KNOWN AS (AKA)	
STREET ADDRESS, APARTMENT NUMBER, P.O. BOX		CITY	STATE	ZIP CODE	A/C	TELEPHONE #	MOTHER'S MAIDEN NAME
Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:							

SECTION B. Parent/Legal Guardian/Foster Caseworker (Surrogate Parent for First Steps Purposes)

1. Name: _____				
Address: _____				
Street		City	State	Zip Code
Home Telephone: () _____	Office Telephone: () _____	Other Telephone: () _____		
2. Name: _____				
Address: _____				
Street		City	State	Zip Code
Home Telephone: () _____	Office Telephone: () _____	Other Telephone: () _____		

Intake Coordinator/Interviewer:	Address:	Telephone:
Ongoing Service Care -Coordinator(if applicable):	Address:	Telephone:

Participant's Name: _____

SECTION C. List all persons (including participant) who live in your household and provide requested information for each individual.

Name	Relationship	DOB	Marital Status	Gender	Race/Ethnicity	Migrant/Homeless	Education Level	Preg (Y/N) # Fetuses*	US Citizen (Y/N)**	PMP (Y/N)	SSN#	Recipient ID	Ins Y/N	v if applying for Healthwise

*Attach medical documentation, including date pregnancy began and estimated due date

**Record immigration status on supplemental form.

TOTAL HOUSEHOLD SIZE _____ ADJUSTED HOUSEHOLD SIZE _____ TOTAL APPLYING FOR HOOSIER HEALTHWISE _____

SECTION D. Income Verification ([Attach additional pages if needed to document income verification.](#))

	1		2		3		MONTHLY GROSS INCOME TOTAL
NAME OF PERSON RECEIVING INCOME ?	Gross Amount	How Often	Gross Amount	How Often	Gross Amount	How Often	
Wages/Fees/Commissions/Tips/Sick Benefits							
Social Security/SSI (SSI NOT counted for CSHCS)							
Dividends/Interest on Savings							
Unemployment Compensation/Strike Benefits							
Alimony/Child Support							
Regular Contributions from persons not living in the household							
Other including: Trustee Assistance, Farm Income, Rental Income, Pensions, Annuities, Trusts, Royalties, Estates, and Military Compensation							

Hours Worked Per Week: 1. _____ 2. _____ 3. _____

Total Household Gross Income: \$ _____

Proof of Income was verified (check stub, letter, tax form, or written statement) by _____

Signature

If no income, how are you supported? _____

Is this month's income the same as the previous three months? ☐ YES ☐ NO

Income Verification sent to the employer (date) _____

Are you currently paying child care to maintain employment? ☐ YES ☐ NOIs Participant: Blind/Disabled? ☐ YES ☐ NO Receiving SSI? ☐ YES ☐ NODo you pay for care of an incapacitated adult? ☐ YES ☐ NODoes anyone living in the household pay support payments? ☐ YES ☐ NO

MCH Income Elig: ____ -0- pay ____ <25% pay ____ 25% pay ____ 50% pay ____ 75% pay ____ 100% pay ____ Ext. Circumstances

PART II - SOCIAL HISTORY INTERVIEW**SECTION A. Participant Information****Date of Interview:** _____

Participant's Name: _____

Participant's Current School/Child Care Provider: _____ Grade Level: _____

School District of Residence: _____

SECTION B. Reason for Referral to CSHCS/FS/MCH/HH

Review the reason(s) for referral with the family members. Include medical condition/diagnosis requiring assistance.

SECTION C. Screening/Assessment/Testing History

Please list dates of previous screening, assessments or other tests (including birth or developmental screening, vision and hearing, speech, gross and fine motor movement, adaptive skills, cognitive abilities, etc.).

Date	Test Administered	By Whom	Results
	Vision		
	Hearing		
	Lead Screening		

Comments: _____

SECTION D. Health Care Received in the Past 12 Months (Copy additional pages of this section as needed.)

List primary care physician for all well-child care including immunizations and illness, dentist and medical care by specialty type.

Name of Primary Care Physician:		PMP #	Date Last Seen:
Address:		Telephone: ()	Fax: ()
Physician Speciality:			
Name of Dentist:		PMP #	Date Last Seen:
Address:		Telephone: ()	Fax: ()
Circle:	Well Child Care/Clinic Services Vision Specialty (Type: _____)	Hospital/ER	
Name:		PMP #	Date Last Seen:
Address:		Telephone: ()	Fax: ()
Reason(s) Seen:			
Circle:	Well Child Care/Clinic Services Vision Specialty (Type: _____)	Hospital/ER	
Name:		PMP #	Date Last Seen:
Address:		Telephone: ()	Fax: ()
Reason(s) Seen:			
Circle:	Well Child Care/Clinic Services Vision Specialty (Type: _____)	Hospital/ER	
Name:		PMP #	Date Last Seen:
Address:		Telephone: ()	Fax: ()
Reason(s) Seen:			
Circle:	Well Child Care/Clinic Services Vision Specialty (Type: _____)	Hospital/ER	
Name:		PMP #	Date Last Seen:
Address:		Telephone: ()	Fax: ()
Reason(s) Seen:			

SECTION E. What is Happening Now for the Participant and Family?**1. What kinds of support and community resources are presently used by your family and/or child:**

Family/Child Services: (C=currently enrolled, P=pending, include date of application)		Economic Support Services: (C=currently enrolled, P=pending, include date of application)	
	Adoption Services		TANF (Temporary Assistance to Needy Families)
	Child Care Assistance		Food Stamps
	Employment Services		WIC
	Legal Services		SSI
	CSHCS		Housing
	Medicaid (M.A.D.)/Hoosier Healthwise		Utility Assistance
	Other:		Other:

2. Discuss referral to community resources with family for any "Yes" responses

Do you need assistance with:

- a. Housing/utilities needs? ☐ YES ☐ NO
- b. Transportation to get you to appointments, health care and other services that you and/or your child need? ☐ YES ☐ NO
- c. Help with providing food or nutritional advice for your family/child? ☐ YES ☐ NO
- d. Are there health care or other special health issues that you need help with for any family member? ☐ YES ☐ NO
- Describe: _____
- e. Support with other issues such as parenting, family relations, legal issues or general personal safety? ☐ YES ☐ NO
- f. Are you or your child around others who smoke at home, work or other places? ☐ YES ☐ NO

3. What type(s) of adaptive equipment is currently used by your child? (v accordingly)

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Walker | <input type="checkbox"/> Splints/AFO's (ankle, foot, orthosis) | <input type="checkbox"/> Eye Glasses |
| <input type="checkbox"/> Adaptive Seating | <input type="checkbox"/> Adaptive Bathing | <input type="checkbox"/> Assistive Communication Device(s) | <input type="checkbox"/> Braces |
| <input type="checkbox"/> Feeding Aids | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

4. What medical, health equipment or supplies are routinely used by your child? (v accordingly)

- | | | | |
|---|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Apnea Monitor | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Prescription Drugs | <input type="checkbox"/> Tube Fed |
| <input type="checkbox"/> Ventilator Dependent | <input type="checkbox"/> Other: _____ | | |

5. Current Medications (specify dose, frequency and purpose)

Medication	Dosage	Frequency	Purpose

6. Special Diet: ☐ YES ☐ NO Type: _____

7. Allergies: _____

NOTE: *Foster/Adoptive Parent may not have the following detailed information. Provide as much information as possible.*

SECTION F. Developmental Milestones

This is a list of developmental milestones. **Please give the approximate age when your child did each of the following.** If you can't remember the specific age, but know that your child has mastered this skill, simply v.

FEEDING SKILLS					
	Formula/Breast fed only		Needs to be fed		Eats solid foods
	Uses cup independently		Needs assistance with feeding		Feeds self w/spoon
	Eats solid foods only		Holds own bottle		Feeds self w/fork
	Sucks/chews on crackers		Finger feeds		Tube fed

Comments: _____

UPPER BODY SKILLS					
	Head needs support		Rolls over		Sits independently
	Holds head steady		Sits with support		Pincher grasp

Comments: _____

LOWER BODY SKILLS, MOBILITY					
	Scoots		Cruises holding on to things		Runs, skips and/or jumps
	Crawls on hands and knees		Walks with assistance		Can climb stairs
	Pulls to standing		Walks independently		Other: _____

Comments: _____

COMMUNICATION SKILLS					
	Eye gazes (familiar face, name, voice)		Smiles		Uses single words/phrases
	Grunts		Points		Talks in sentences
	Babbles, no words yet		Uses eye gestures		Speaks clearly
	Responds to sound		Responsive to directions given		Other: _____

Comments: _____

SELF HELP OR ADAPTIVE SKILLS					
	Cooperates in dressing		Dresses independently		Fully toilet trained
	Removes socks, shoes		Wears diapers		Other: _____
	Needs to be dressed		Toilet training in process		Other: _____

Comments: _____

SECTION G. Pregnancy, Birth and General Health History

Is there anything important about the pregnancy with this child, or his/her birth or early health history that will be helpful to us in determining your child's eligibility or planning services together? (If the family member reports "Yes" conduct the in-depth interview as follows. This information is often not available from families who have adopted children.) Check appropriate boxes.

1. Foster Child ☐ YES ☐ NO Age at DFC placement: _____

2. Child was adopted ☐ YES ☐ NO Age at adoption: _____

3. What month of the pregnancy did you start to see a medical provider? _____

Did you have regular medical care during this pregnancy? ☐ YES ☐ NO

4. During the pregnancy with this child, were any of the following present?

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Early contractions | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Non-prescription drugs | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Injury | <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Virus: (type) _____ |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Flu | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Swollen ankles | |
| <input type="checkbox"/> Early bed rest | <input type="checkbox"/> German measles | <input type="checkbox"/> Measles | <input type="checkbox"/> Threatened miscarriage | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other illness: (type) _____ | | <input type="checkbox"/> Other illness: (type) _____ | | |

Comments: _____

SECTION G. Pregnancy, Birth and General Health History (continued)

5. Type of delivery:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Vaginal delivery | <input type="checkbox"/> Breech delivery | <input type="checkbox"/> Twin |
| <input type="checkbox"/> Cesarean delivery | <input type="checkbox"/> Premature delivery | <input type="checkbox"/> Other: _____ |

Comments: _____

6. Was any anesthesia used during childbirth? ☐ YES ☐ NO Type: _____7. Were there any problems/complications *during* delivery?

- | | | |
|--------------------|--|-------------|
| 1) For the mother: | <input type="checkbox"/> YES <input type="checkbox"/> NO | What? _____ |
| 2) For the child: | <input type="checkbox"/> YES <input type="checkbox"/> NO | What? _____ |

8. Were there any problems/complications *after* delivery?

- | | | | |
|--------------------|--|------------|----------------------|
| 1) For the mother: | <input type="checkbox"/> YES <input type="checkbox"/> NO | Why? _____ | Length of stay _____ |
| 2) For the child: | <input type="checkbox"/> YES <input type="checkbox"/> NO | Why? _____ | Length of stay _____ |

9. Newborn Status

- | | | |
|---|---|---|
| <input type="checkbox"/> Healthy, no problems | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Ventilator (how long): _____ |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Delayed crying | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cord around neck |
| <input type="checkbox"/> Other: _____ | | |

10. What was the child's birth weight? _____

11. APGAR Score? _____ (@ 1 minute) _____ (@ 5 minutes)

12. Where was the child born? _____
Hospital Name/City/State

13. Length of hospital stay: Child: _____ days Mother: _____ days

14. Was the child transferred to another hospital? ☐ YES ☐ NOIf yes, which hospital? _____
Hospital Name/City/State

15. How has your child's general health been since birth?

- | | | |
|---|---|--|
| <input type="checkbox"/> Healthy, no problems | <input type="checkbox"/> Surgery(ies) | <input type="checkbox"/> Numerous ear infections |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Repeated hospitalizations |
| <input type="checkbox"/> Vomiting problems | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Comments: _____

NOTE BELOW ANY ADDITIONAL INFORMATION INCLUDING DISCHARGE SUMMARY OR REPORTS PROVIDED DURING THIS INTERVIEW.